

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

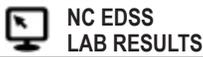
PLAGUE

Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 29

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name, First, Middle, Suffix, Maiden/Other, Alias, Birthdate (mm/dd/yyyy), SSN



Verify if lab results for this event are in NC EDSS. If not present, enter results.

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

CLINICAL FINDINGS

Is/was patient symptomatic for this disease?
If yes, symptom onset date (mm/dd/yyyy):
Fever
Fatigue or malaise or weakness
Chills or rigors
Shock
Swollen lymph nodes
Headache
Stiff neck
Meningitis
Elevated CSF protein
Elevated CSF cell count
Muscle aches / pains (myalgias)
Cutaneous ulcer
Sore throat
Pharyngitis
Cough

Shortness of breath/difficulty breathing/ respiratory distress
Acute Respiratory Distress Syndrome (ARDS)
Pneumonia
Did the patient have a chest x-ray?
Chest CT scan performed
Bacteremia
Septicemia/sepsis
Disseminated intravascular coagulation (DIC)
Other symptoms, signs, clinical findings, or complications consistent with this illness
Clinical classification

PREDISPOSING CONDITIONS

Any immunosuppressive conditions?
Specify

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours?
Hospital name:
City, State:
Hospital contact name:
Telephone:
Admit date (mm/dd/yyyy):
Discharge date (mm/dd/yyyy):

TREATMENT

Did the patient take an antibiotic as treatment for this illness?
Did the patient take an antibiotic as prophylaxis secondary to being a contact of a confirmed case?
Were antibiotics taken before culture specimen collected?
Specify culture site(s)
Were antibiotics given in the 24 hours before culture?
Was antibiotic prophylaxis given prior to illness onset?

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

CLINICAL OUTCOMES

Survived? Y N U

Status at time of report:

Fully recovered

Survived but experiencing sequelae (residual deficit from illness) at time of report

Died? Y N U

If yes, died from this illness? Y N U

Patient died in North Carolina? Y N U

County of death: _____

Died outside NC? Y N U

Specify where: _____

Autopsy performed? Y N U

Facility where autopsy was performed _____

Patient autopsied in NC? Y N U

County of autopsy: _____

Autopsied outside NC, specify where: _____

Cause of death: _____

Date of death (mm/dd/yyyy): _____

TRAVEL/IMMIGRATION

The patient is:

Resident of NC

Resident of another state or US territory

Foreign Visitor

Refugee

Recent Immigrant

Foreign Adoptee

None of the above

Did patient travel during 14 days prior to onset of symptoms? Y N U

List travel dates and destinations:
From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

List persons and contact information:

Additional travel/residency information:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 14 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____

Dates of contact: from ____/____/____ until ____/____/____

During the 14 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N

If yes, specify and give details:

Date control measures issued: ____/____/____

Date control measures ended: ____/____/____

Was patient compliant with control measures? Y N

Did local health director or designee implement additional control measures? Y N

If yes, specify: _____

Were written isolation orders issued? Y N U

If yes, where was the patient isolated? _____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? Y N U

Were written quarantine orders issued? Y N

If yes, where was the patient quarantined?

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine? Y N

Notes:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U

Patient a child care worker or volunteer in child care? Y N U

Patient a parent or primary caregiver of a child in child care? Y N U

Is patient a student? Y N U

Type of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U

Give details: _____

OUTDOOR EXPOSURE

During the 14 days prior to onset of symptoms, did the patient participate in any outdoor activities? Y N U

If yes, specify and give details:

Was patient exposed to wild animals? Y N U

If yes, specify animal(s) _____

Did patient handle the animal? Y N U

Animal was:
 Alive Dead Unknown

Was animal sick? Y N U

Exposed on (date) (mm/dd/yyyy): ____/____/____

Until (date) (mm/dd/yyyy): ____/____/____

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 14 days prior to onset of symptoms, did the patient work in a laboratory? Y N U

If yes, specify and give details:

VECTOR EXPOSURE

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to fleas? Y N U

If yes, specify _____

Exposed on (date) (mm/dd/yyyy): ____/____/____

Until (date) (mm/dd/yyyy): ____/____/____

Frequency:
 Once
 Multiple times within this time period
 Daily

Exposure setting _____

City/county of exposure _____

State of exposure _____

Country of exposure _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify: _____

Has the patient ever served in the U.S. military? Y N U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

ANIMAL EXPOSURE

During the 14 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U
If yes, specify and give details:

Household pets (especially cats)? Y N U
If yes, specify and give details:

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? Y N U
If yes, specify and give details:

Did the patient handle any animals? Y N U
Did it/they appear sick? Y N U

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? Y N U
If yes, specify and give details:

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? Y N U
If yes, specify and give details:

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U
If yes, specify and give details:

Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U
If yes, specify and give details:

Did patient work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? Y N U
If yes, specify and give details:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
Who was interviewed?

Were health care providers consulted? Y N U
Who was consulted?

Medical records reviewed (including telephone reviews with provider/office staff)? Y N U
Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
Specify location:

In NC
City _____
County _____

Outside NC, but within US
City _____
State _____
County _____

Outside US
City _____
Country _____

Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

VACCINE

Has patient/contact ever received plague vaccine? Y N U
If yes, provide the vaccine name, source of vaccine, date of vaccination, and source of vaccine information:

Plague (*Yersinia pestis*)

1996 CDC Case Definition

Clinical description

Plague is transmitted to humans by fleas or by direct exposure to infected tissues or respiratory droplets; the disease is characterized by fever, chills, headache, malaise, prostration, and leukocytosis that manifests in one or more of the following principal clinical forms:

- Regional lymphadenitis (bubonic plague)
- Septicemia without an evident bubo (septicemic plague)
- Plague pneumonia, resulting from hematogenous spread in bubonic or septicemic cases (secondary pneumonic plague) or inhalation of infectious droplets (primary pneumonic plague)
- Pharyngitis and cervical lymphadenitis resulting from exposure to larger infectious droplets or ingestion of infected tissues (pharyngeal plague)

Laboratory criteria for diagnosis

Presumptive

- Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination or
- Detection of F1 antigen in a clinical specimen by fluorescent assay

Confirmatory

- Isolation of *Y. pestis* from a clinical specimen or
- Fourfold or greater change in serum antibody titer to *Y. pestis* F1 antigen

Case classification

Suspected: a clinically compatible case without presumptive or confirmatory laboratory results

Probable: a clinically compatible case with presumptive laboratory results

Confirmed: a clinically compatible case with confirmatory laboratory results